King County Disability Retirement Board
Guide for LEOFF-I Members

"HOW TO FILE A CLAIM FOR MEDICAL OR DENTAL BENEFITS"

King County Disability Retirement Board
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Guide to LEOFF-I Members
For Preparation of Medical Expense
Reimbursement Claims to the Disability Board

1. Forms needed:

   a. KCDRB Form #5, "Employer's Statement: Claim for Reimbursement of Medical Expense" (to be completed by the employer);

   b. KCDRB Form #6, "LEOFF-I Member's Claim for Reimbursement of Medical Expenses" (to be completed by the member or members' designated representative);

   c. KCDRB Form #7, "Physician/Health Provider's Statement" (to be completed by physician/health care provider);

   d. KCDRB Form #8, "Provider's Treatment Plan" (to be completed by providers of mental health, chiropractic and substance abuse treatment exceeding one month or, in case of additional medical services, continuing more than two (2) visits for the same illness or condition.)

   e. KCDRB Form #9, "Assessment of Need for Nursing Home or Assisted Living Care" (to be completed by a responsible family member or appointed representative, as well as the facility Director of Nursing and the primary care physician.)

   f. KCDRB Form #10, "Assessment of Need for Home Health Care" (to be completed by a responsible family member or appointed representative, as well as the home health care provider or agency and the primary care physician.)

   g. KCDRB Form #11, "Dental Expense Claim" (to be completed by the dentist and signed by the member):

2. Prior to completion of these forms, the member needs to do the following:

   a. Request the physician/health care provider/dentist submit bills for services to any and all sources of reimbursement/coverage available to the member. This includes:

      (1.) any health care plan the member is currently enrolled in through his/her employer or self-funded insurance;

      (2.) spouse's insurance which provides coverage;

      (3.) Medicare Parts A and B;

      (4.) Benefits provided under other pension plans, Workman's Compensation or Social Security.

2. Prior to completion of these forms (continued):

   b. Check with employer (or, if retired, with LEOFF-I employer at time of retirement) for information about coverage and benefits available now.

   c. Collect all bills, statements and receipts for payment of services from all health care providers related to the illness/injury/disability for which claim will be made (including insurance carrier's "Explanation of Benefits" which are sent to members.)

3. Member initiates the claim process by obtaining the necessary forms from his/her employer/personnel clerk/benefits specialist at his/her place of employment. The employer may request additional forms from the Disability Board Clerk at telephone: (206) 263-6394.

   a. Form #5: To be completed by the employer.

   b. Form #6: To be completed by member within six (6) months of receipt of the original billings from health care providers.

      Member completes Form #6 and attaches copies of billing statements, receipts, insurance carrier's "Explanation of Benefits", and other supporting documents.

   c. Form #7: Member obtains this form from his/her employer and requests completion by his/her physician/health care provider. It is necessary for the employer to attach this form to the claim Form #6 prior to forwarding to the Board.

   d. Form #8: If treatment is continuous and exceeds one (1) month, or more than two (2) visits for the same illness or condition, member must request the health care provider prepare and submit a treatment plan on KCDRB Form #8 which will be attached to the other claim forms and processed as requested.

[continued]:

e. Form #9: If member applies to the Board for reimbursement of costs for care provided by a nursing home or assisted care facility, Form #9 is to be used in place of Form #7. Information requested on Form #9, is to be provided by:

(1.) the member, a responsible family member or other appointed representative;

(2.) the Director of Nursing at the care facility, and

(3.) the member's primary care physician or physician in charge of care at the facility.

Necessary **required** information must also be collected and attached to Form #9 before it can be submitted, along with Form #6, to the employer. This required information includes:

(1.) an itemized statement of costs showing daily residence rate, charges for medical supplies, medications, and personal care items, service charges for additional care services, etc.);

(2.) a copy of the hospital discharge summary if member started residence in the facility within six (6) months of hospitalization;

(3.) a list of all medications with name, dosage, and frequency prescribed; and

(4.) treatment plans for each service or therapy prescribed.

f. Form #10: If member applies to the Board for reimbursement of costs for in-home health care provided by a certified employee of a home health care agency,

Form #10 is to be used in place of Form #7. Information requested on Form #10, is to be provided by:

(1). the member, a responsible family member or other appointed representative;
(2.) the home health care provider or agency, and
(3.) the member's primary care physician or physician in charge of care.

Necessary **required** information must also be collected and attached to Form #10 before it can be submitted, along with Form #6, to the employer. This required information includes:

(1.) an itemized statement of costs showing hourly rates of the caregiver;

(2.) a copy of the home health care agency's state license;

(3.) a copy of the care/treatment plan for in-home care;

(4.) a list of all medications with name, dosage, and frequency prescribed; and

(5.) a list of additional care services employed and treatment plan(s) for each service.

g. Form #11: Member can apply for payment of dental expense up to maximum allowed under Rule 9.9. Form #11 must be completed by the dentist and signed by the member. Submit Form #11 with Form #6 and the invoice directly to your LEOFF-I employer.

Suggestions to expedite claims:

1. Members need to consult with their health insurance carriers or their employers to learn what is or is not covered under their existing health insurance.

2. All medical expenses incurred and claimed for reimbursement have to be submitted to the member's health insurance either by the member, employer or health care provider, before the claim is sent to the Board for approval.

3. The Board considers *only* the medical necessity of the treatment, service and/or equipment prescribed by the physician/health care provider and the reasonableness of the charges for those services. The Board reviews and approves reimbursement/payment of claims by the employer. The Board does not pay claims.

4. Active members should contact their representative on the Board if there are questions about coverage and procedures to file claims.

5. All claims must be submitted on appropriate forms with supporting receipts to member's employer within six (6) months of the member's receipt of the initial billing.

6. Members must support claims for reimbursement or payment of medical treatment or other health care services with information from the physician/health care provider describing the service, explaining the medical necessity, and including a billing statement itemizing charges. (This is Form #7 or, for claims for nursing home/assisted care costs, use Form #9.)

7. Test results and diagnostic studies to support claims (e.g., audiograms when claiming reimbursement for hearing aids) are needed and should be attached to Form #7.

INSTRUCTIONS FOR COMPLETION OF FORM #9 OR FORM #10

"Assessment of Need for Nursing Home or Assisted Living Care/ Home Health Care"

Introduction:

Under Board Rule 9.10-E, G and H, a LEOFF-I member may submit an application for prior approval of reimbursement of costs for long-term custodial care in a nursing home, residential placement in an assisted care facility, or in-home health care services.

The procedure for submission of a claim requires completion of Form #9, **"**Assessment of Need for Nursing Home or Assisted Living Care", or Form #10, Assessment of Need for Home Health Care" (which ever is applicable) **and** Form #6, "Member's Claim for Reimbursement of Medical Expenses". Additional required information must then be attached (see below). Finally, all forms and attachments are submitted to the LEOFF-I employer who will complete the application and forward it to the Disability Board for review.

NOTE: Each claim will be considered on a case-by-case basis by the Disability Board. No claim can be brought before the Board unless all required forms and information have been completed and included in the application packet. Any claim that is submitted with information missing will be returned to the employer or member for completion.

Filling out Form #9:

Form #9, is a two-sided form with three sections. The first (top) section is to be completed by the LEOFF-I applicant.

> Member's identifying information can be filled out by a responsible family member, legal guardian or other appointed representative.
>
> An itemized statement of costs must be attached to the form. This statement should include the facility daily residence rate, charges for medical supplies, medications, and personal care items, and other service charges for additional care.

The second section is to be completed by the Director of Nursing of the facility. If the member was hospitalized within six months preceding placement in the facility, the hospital discharge summary must be provided by the Director of Nursing and attached to Form #9.

INSTRUCTIONS FOR COMPLETION OF FORM #9 OR FORM #10
"Assessment of Need for Nursing Home or Assisted Living Care/Home Health Care"
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The reverse side of Form #9 is to be filled in, signed and dated by the medical physician in charge of the member's care, be it his primary care physician or the physician attending to the care of all residents in the facility (a M.D. designated as "Medical Director"). A list of current medications and treatment plans for each therapy prescribed must be provided by the physician and attached to Form #9.

The completed Form # 9, with required attachments, is to be submitted to the LEOFF-I employer who, in turn, will add an employer's form and submit the completed application to the Disability Board office.

Any questions about the form, procedures for submitting a claim, or other Board policies can be addressed to the Board Clerk Gail Morris at (206) 263-6394.

Filling out Form #10:

Form #10, is a two-sided form with three sections. The first (top) section is to be completed by the LEOFF-I applicant.

> Member's identifying information can be filled out by a responsible family member, legal guardian or other appointed representative.
>
> An itemized statement of costs must be attached to the form. This statement should include the in-home caregiver's daily, charges for medical supplies, medications, and personal care items, and other service charges for additional care.

The second section is to be completed by the home health provider or agency. Additional documents are **required**:

- state license of the agency
- licensure and/or certification of the care giver(s),
- a copy of the rate sheet and itemized invoice for services,
- a copy of the care/treatment plan.

INSTRUCTIONS FOR COMPLETION OF FORM #9 or FORM #10
"Assessment of Need for Home Health Care/Home Health Care"
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The reverse side of Form #10 is to be filled in, signed and dated by the medical physician in charge of the member's care, or the physician prescribing the in-home health care.

A list of current medications and treatment plans for each therapy prescribed **must** be provided by the physician and attached to Form #10.

The completed Form # 10, with required attachments, is to be submitted to the LEOFF-I employer who, in turn, will add an employer's form and submit the completed application to the Disability Board office.

Any questions about the form, procedures for submitting a claim, or other Board policies can be addressed to the Board Clerk Gail Morris at (206) 263-6394.